The National Emergency Medical Services Advisory Council (NEMSAC)
Meeting Summary

September 7–8, 2016

The FHI 360 Conference Center, 8th Floor
1825 Connecticut Ave., NW
Washington, DC 20009

These minutes, submitted pursuant to the Federal Advisory Committee Act, are a summary of discussions that took place during the National Emergency Medical Services Advisory Council meeting on September 7–8, 2016. See Appendix A for a list of council members.

Contents

Day 1: Wednesday, September 7, 2016 3
- Call to Order, Introductions, and Opening Remarks 3
- New Features in NEMSAC Support Contract 4
- Federal Liaison Update 4
- Diversion of Ketamine Patients 7
- NEMSAC Committees Updates and Discussion 7
- Public Comment 11
- Closing Remarks and Adjournment 11

Day 2: Thursday, September 8, 2016 12
- Reconvene 12
- Approval of April 18–19, 2016 Meeting Minutes 12
- NEMSAC Committee Reports/Updates/Discussion/Action 12
- Election of Chair and Vice Chair 16
- NEMSAC Annual Report 16
- Public Comment 16
- NEMSAC Next Steps 17
- Adjournment 18
- Appendix A: Council Members Present at Meeting 19

Day 1: Wednesday, September 7, 2016

Call to Order, Introductions, and Opening Remarks

John Sinclair, NEMSAC Chair
Susan McHenry, M.S., EMS Specialist, Office of Emergency Medical Services, National Highway Traffic Safety Administration (NHTSA), Department of Transportation (DOT); Designated Federal Officer (DFO)

Mr. Sinclair called the meeting to order at 8:30 a.m. EST. Ms. McHenry served as DFO for NEMSAC, and they welcomed participants. The morning's plenary session, which included public comment, was followed by committee meetings in the afternoon. Wednesday's agenda included election of a new NEMSAC chair and vice chair.

The next NEMSAC meeting is scheduled for December 1–2, 2016.

Ms. McHenry welcomed federal partners and liaisons, including Ray Mollers, M.S.A., EMS program manager for the Department of Homeland Security (DHS), and Gregg Margolis, Ph.D., director of the Division of Health Systems and Health Policy for the Department of Health and Human Services (HHS). Council members introduced themselves and disclosed new conflicts of interest. Dr. Cunningham has had new appointments since the April 2016 meeting. Dr. Shah said a portion of his salary is funded through the Health Resources and Services Administration (HRSA).

Guests also introduced themselves. They represented a variety of emergency service agencies from a broad range of locations.

Mr. Sinclair and Anne Montera, B.S.N., NEMSAC vice chair, attended the last meeting of the Federal Interagency Committee on EMS (FICEMS) and presented the work of NEMSAC. They received very positive feedback. One topic discussed at the meeting was EMS reimbursement. A representative from the Centers for Medicare and Medicaid Services (CMS) said CMS wanted to entertain some additional guidelines.

With new leadership coming in, Mr. Sinclair said EMS is at a critical time in history. A new executive branch next year in the federal government could provide an opportunity for fundamental changes. Council members should be mindful of what the group does as a council, where it is headed on the topic of financing and reimbursement, and where EMS stands on innovative practices. He would not want NEMSAC to squander its moment in history by not being bold. Mr. Sinclair encouraged the council to be bold and courageous and make a statement.

Ms. McHenry introduced Jon Krohmer, M.D. the new director of the NHTSA Office of Emergency Medical Services. Dr. Krohmer said he looked forward to the opportunity to work with NEMSAC, EMS departments around the country, and federal partners. Mr. Sinclair commented that Dr. Krohmer is a "paramedic at heart."

New Features in NEMSAC Support Contract

Ms. McHenry

Ms. McHenry said NEMSAC has some new resources, in part because of the efforts of Noah Smith, NHTSA EMS specialist. With the new resources, NEMSAC will be able to have four meetings per year, with the fourth 2016 meeting scheduled in December and 2017 dates to be announced. NEMSAC also is working with a contractor, The Event Planning Group (TEPG), for onsite staff support in the NEMSAC office. The council also expects to have greater technical assistance and support.

Even more significantly, NEMSAC will become involved with emerging issue papers, incorporating that work into the TEPG contract to support the work of committees. TEPG also will provide assistance to produce the annual report and help with the time-consuming appointment process, which will occur in spring 2017.

Federal Liaison Update

Dr. Margolis, HHS; Diane Pilkey, R.N., M.P.H. HRSA, HHS; Mr. Mollers, DHS; Laurie Flaherty, R.N., M.S.N., NHTSA Office of EMS, DOT; Noah Smith, M.P.H., NHTSA Office of EMS, DOT; Gamunu Wijetunge, M.P.M., NHTSA Office of EMS, DOT

The NEMSAC charter specifies that federal liaisons from DOT, DHS, and HHS inform NEMSAC of ongoing or planned Department activities related to EMS and update their respective Departments on NEMSAC activities.

Dr. Margolis, HHS

Dr. Margolis said the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) has been busy with the budget, hurricanes, and response to the Zika virus. Zika is the infectious disease that HHS currently spends most of its time with. It might not have large implications for EMS, but it has profound public health implications, particularly for anyone involved in family planning. He asked council members to think about the kind of public health activities and educational perspectives EMS providers could suggest for Zika preparedness.

Dr. Margolis noted that ASPR recently signed a contract that will help state and local EMS offices build capacity to transport patients with serious infectious diseases such as Ebola. Also, in the next few weeks it will release Until Health Arrives, a curriculum with guidelines for bystanders who are present when injury occurs. The main focus is bleeding control, recognizing that it is one of the most preventable causes of traumatic death before EMS help arrives.

Ms. Pilkey, HRSA, HHS

HRSA recently received approval from the federal Office of Management and Budget for three new performance measures it has been working on with its state partnership grantees. Submission of data compliant with the National EMS Information System (NEMSIS) will ensure quality pediatric data as well as a pediatric care coordinator and pediatric-specific equipment.

HRSA also has two grant programs. State Partnership Regionalization of Care programs focuses

on developing and implementing regionalized systems of care, particularly in tribal communities. California, Montana, and New Mexico received grants. HRSA also funded, as of September1, five targeted issue grants that focus on improving pediatric health outcomes related to emergency care. Four focus on prehospital care and one on emergency department care.

HRSA also has taken a new direction with its national Emergency Medical Services for Children (EMSC) resource center, expanding its focus to an EMSC Innovation and Improvement Center (https://emscimprovement.center/). It will work on improvement strategies with national and federal partners, as well as its grant programs.

Mr. Mollers, DHS

Mr. Mollers noted that the Federal Emergency Management Agency could be an important contributor to EMS topics. He had no significant changes to report about DHS fiscal and political positions since the April NEMSAC meeting. The leadership is committed to staying in place, whatever happens politically.

Mr. Mollers said he hoped DHS could develop more data and tools to combat human trafficking. Movement also continues on tactical EMS. DHS continues to work with stakeholders to reach the end result of special recertification for tactical EMS. Another issue is canine handlers, although the medical care guide for canine handlers that Mr. Mollers reported on in April has not yet been published. The Secret Service also is planning on developing related canine guidelines.

DHS continues to support guidelines to follow in the case of active shooters and also continues to support the Recognition of EMS Personnel Licensure Interstate CompAct (REPLICA).

Ms. Flaherty, NHTSA Office of EMS, DOT

Ms. Flaherty, coordinator of the National 911 Program, helps to coordinate 911 services at the local, state, and national levels. Responsible for grant programs to benefit public safety answering points (PSAPs), the National 911 Program recently completed a 3-year project that establishes recommended guidelines for minimum training of the 911 community.

The discretionary budget of the 911 Program has more than doubled, providing the opportunity to consider how to support 911 systems at state and local levels. Efforts will consider establishing a uniform dataset for the computer-aided dispatch (CAD) data that is currently collected and developing a dataset system for all PSAPs. The 911 Program also is currently about halfway through a large project to figure out the cost of deploying the next generation of 911. Most of the PSAPs in the country will upgrade their basic infrastructure, and Congress has requested a cost estimate. Finally, $115 million has been designated for the 911 grant program.

Mr. Smith, NHTSA Office of EMS, DOT

Mr. Smith said the national EMS database is transitioning from contractors at the University of Utah to an in-house system that NHTSA is developing. This will help state and local providers understand that the EMS data rest with NHTSA and are part of the core data system, increasing

the use of the data and its availability to the public.

The NHTSA Office of EMS has begun the process of envisioning what the next generation of the NEMSIS technical assistance center will look like. In July 2016, NHTSA hosted a summit of more than 30 EMS and health care leaders and software vendors called Beyond Data Collection. The proceedings will be published in October and will help form the EMS agenda for the future, with the goal of a data-driven program.

The National Academies of Sciences, Engineering, and Medicine recently issued a report about a health care and trauma system that would incorporate military experience to reduce preventable traumatic death in this country. Mr. Smith urged NEMSAC members to read the recommendations (http://www.nationalacademies.org/hmd/Reports/2016/A-National-Trauma-Care-System-Integrating-Military-and-Civilian-Trauma-Systems.aspx). One recommendation to NHTSA was to better coordinate information systems and databases.

NHTSA has discussed the idea of preventable death from traumatic injury, but more data are needed to support these discussions. More than 35,000 people died on American roadways in 2015, an 8 percent increase from the previous year. Between 40 and 45 percent of people who die in roadway incidents die after the arrival of EMS. Those deaths are not necessarily all preventable, but there is great opportunity for EMS to improve the trauma system.

NHTSA and the EMS Office also are working on EMS Compass, which has the goal of helping EMS systems measure and improve the quality of care at national, state, regional, and local levels with new performance measures based on the latest version of NEMSIS. Also, the NHTSA EMS Office will fund projects to produce reports based on solid information. One white paper now in progress is a synthesis of literature on the use of lights and sirens in EMS.

Mr. Wijetunge, NHTSA Office of EMS, DOT

NHTSA is working with other agencies to develop evidence-based guidelines for managing opioid overdose with a funding package to support a systematic review of relevant literature. The state of New Hampshire and New Orleans EMS made presentations on a webinar last week to highlight best practices to use data to track the opioid epidemic. Also, the Office of National Drug Control Policy (ONDCP) will work with the Centers for Disease Control and Prevention to fund surveillance of opioid use in 11 hard-hit states, and NHTSA will cosponsor a meeting on management of opioids in trauma in Albuquerque this week.

And addendum to the instructional guidelines of the Model Uniform Core Criteria (MUCC) for Mass Casualty Incident Triage is being developed and will be published in coming months.

NHTSA is reviewing comments about the EMS agenda and issued a request for quotes to add contractors; it closed a few weeks ago. There should be an announcement later this year.

Mr. Wijetunge reminded council members that this month marks the 50th anniversary of Highway Safety Act and the book on Accidental Death and Disability. These ultimately led to the modern EMS system.

Diversion of Ketamine Patients

The issue of diversion of patients who take ketamine came up on a listserv from a user in Nevada. It relates to the Emergency Medical Treatment and Labor Act (EMTALA) and selected diversion of patients who use ketamine. One hospital says it will immediately divert a patient who has received ketamine, because it cannot manage such a patient in its emergency department. Can a hospital do that, and must EMS respect it? This could lead to a slippery slope. Dr. Braithwaite said she had huge concerns about where this could go.

Dr. Monosky said it seems this should be an issue for the Joint Commission on Accreditation of Healthcare Organizations, for accreditation of a hospital. Mr. Robbins said the fundamental basis of EMTALA is to require at least assessment of a patient before diversion. He added that it would behoove NEMSAC to get legal advice about this. Mr. Sinclair directed the relevant committees to discuss the diversion of ketamine patients in their afternoon meetings.

NEMSAC Committees Updates and Discussion

Ad Hoc Committee: Scope of Practice Model and Administration of Narcotic Antagonists
Ms. Montera

Jose Melero, of the ONDCP, said the continued partnership and assistance of every discipline and community is needed to successfully address the opioid epidemic. There were more than 28,000 opioid-related deaths in 2014—78 per day. In addition, other public health and public safety consequences are related to opioid use disorder.

All first responders must have access to the tools they need to reverse an opioid overdose. EMS providers are on the frontline of this crisis. In 2015, EMS administered naloxone at least 215,522 times to 172,937 patients. Modifying the EMS scope of practice model (SOPM) would provide just one tool, but it is an important one. ONDCP was pleased to see that NEMSAC's draft advisory encourages urgent action by the states. This is a rapidly evolving area, and NEMSAC's continued leadership and advocacy on behalf of patients and their families is desperately needed.

Discussion

Council members agreed on the consequence of this recommendation. There were questions about the wording and whether it was recommending something that already is being done. Ms. Montera said the intent is that NEMSAC should receive timely response from EMS stakeholders and subject matter experts about the new process after it is developed. Ms. McHenry said the agreement is to develop a literature synthesis for a guideline. The guideline is not yet written.

Dr. Diaz noted that naloxone has been used for decades, but there is little information about long-term effects. Public health and social consequences will not be known for a long time, probably not before the next 20 years. Dr. Shah observed that if the SOPM is to be changed, evidence must be gathered. Dr. Fallat emphasized the importance that this be a living document with the ability to make changes. Ms. Altenhofen noted that EMS providers in rural areas and volunteers currently are not authorized to administer aspirin, Epi-Pen injections, and glucose or measure pulse oximetry. EMS is trying to expand its scope of practice. Another issue is who is

going to pay for this.

Dr. Cunningham emphasized that putting drugs in the hands of police and EMS must be accompanied by education to make a decision about whether the drug should be given. Mr. Hooten emphasized that naloxone is not a cure, and the recommendation must highlight the need for treatment and rehabilitation.

Ad Hoc Committee: REPLICA
Dr. Shah

Dr. Shah said the REPLICA committee attempted to integrate feedback from the April meeting into the draft recommendation that is in the meeting book.

Funding and Reimbursement Committee: EMS System Performance-based Funding and Reimbursement Model
Mr. Baird

EMS is underfunded and needs more resources. NEMSAC is looking for support from NHTSA, FICEMS, and other agencies. There are several approaches to gaining support from Capitol Hill, including CMS rule changes. That could serve as a starting point for full system review.

Mr. Hooten said this issue has been on the NEMSAC agenda for many years, and it is time to finally do something about it and push forward a document that will address the problems.

Discussion

Mr. Sinclair noted that the primary EMS funding model was established in 1966 with the Medicare model of who gets there quickest. It is based on transport, not patient care. It is time to change this to a patient-centric model for financing emergency medical care that is not based only on transport. Mr. Gale suggested a review of models for treatment-without-transportation services provided by EMS. Some citations and definitions were questioned, and Mr. Baird asked council members to email the fine points that are being brought up to him and Mr. Hooten.

Dr. Margolis noted that without changing the law, some of the suggested changes will be difficult to make. Changing Medicare policy is a very heavy lift. Another strategy to consider might be to change Medicaid, other private payer policies, and demonstration projects to build a track record that Medicare can then look at. Some states are working on this, with some success. The funding discussion becomes very important in the context of naloxone and other issues. NEMSAC has a role to play. The law was written in 1966 and is outdated. A pay structure that emphasizes quality rather than fee-for-service is gradually moving in.

Mr. Baird said the advisory is very much a work in process. Mr. Hooten said funding and reimbursement are the most important things NEMSAC will address.

Innovative Practices of the EMS Workforce: Recognizing the EMS Workforce as Essential Decision-Makers Within the Health Care Industry and Assuring Adequate Fiscal Support

Mr. Robbins

The committee made four recommendations. The first is to encourage federal agencies to emphasize EMS when they consider their health care workforce grant funding portfolios. The second is to continue to look for innovative EMS practices, which can reduce health care costs. The third is to recognize EMS practitioners as professionals. The fourth is for FICEMS to pursue discussions with CMS to recognize EMS (ambulance services) as providers under Medicare regulations and develop a plan for comprehensive payment reform to account for changes in prehospital standards of care.

The committee also is working on two other advisories. One is related to research coordination and analysis of research already done, and the other is about renaming practitioners in the EMS field, to get the field into the 21st century.

Data Integration and Technology: Standardized Training for Local Data Managers to Ensure High-Quality Data
Mr. Kaye

The committee recommended that NHTSA and NEMSIS create a training class to provide the foundation EMS data managers need to work with data, providing the tools to advance past the initial data management level and derive the high quality data needed to make good decisions. The field needs the tools to advance beyond the many limitations of the currently available data.

Discussion

Ms. Altenhofen recommended that information technology (IT) education be included in the next iteration of educational standards and that IT be part of continuing education. Mr. Kaye proposed two full days of training to review mechanics and another day to demonstrate understanding of the concepts and how to use them. Much of the IT training could be done online.

Ms. Montera encouraged the Data Integration and Technology Committee to work with the Provider and Community Education Committee to bring needs together, connect the dots, and break down the silos. Ms. White said the Patient Care, Quality Improvement, and General Safety Committee also is working on those issues. She added that training about how to use data effectively involves more than a two-day course; it is an ongoing process.

The group's second discussion point was about sharing patient information through the continuum of care. Currently, it is fragmented and primarily unidirectional. The advisory recommends that FICEMS use a universal health record with a bidirectional flow that includes all venues where patients receive care—outpatient clinics, emergency departments, urgent care centers, hospitals, rehabilitation centers, nursing homes, home care, and long-term care. EMS is part of that. Solving this would result in HL7 (Health Level 7)—a framework for the exchange, integration, sharing, and retrieval of electronic health information—actually meaning something.

Patient Care, Quality Improvement, and General Safety: Updating the Trauma System Agenda

Dr. Fallat

The topic for this advisory was updating the Trauma System Agenda for the Future and the Model Trauma System Planning and Evaluation (MTSPE) document. Injury continues to be a leading cause of death in the United States and the most common cause of death in children. High-functioning trauma systems play a vital role in building and maintaining national, state, local, and tribal resilience against disasters.

The committee recommended that FICEMS develop a strategic plan for supporting integrated trauma system development, bringing together a coalition of federal agencies to support an effort to update and modernize both the Trauma System Agenda for the Future and the MTSPE document, including the Benchmarks, Indicators, and Scoring (BIS) tool. Recommended strategies include an updated approach to trauma care with a more thorough description of methods and opportunities to integrate trauma system programs with public health programs. There also is a need to more fully integrate military and civilian trauma systems.

It is important to address whether an inclusive trauma system will include the growing proportion of the population over age 65, for whom data suggest that trauma center care does not improve survival. The needs of children within the trauma system also must be addressed.

Finally, an important approach is to update the BIS scoring tool to reduce and consolidate the number of indicators, clarify objectivity of the indicators, improve scoring criteria, update indicators related to emergency and disaster preparedness, and identify "essential indicators" that could be useful to facilitate summary comparisons and interim analysis. The economics of trauma treatment and a stronger linkage between systems are other considerations.

Discussion

Dr. Diaz said consideration of survivors' quality of life makes sense. Ms. Altenhofen said she thought discussion of local and federal division of trauma systems should be tabled until NEMSAC has a "mothership" doctrine. She suggested changing the model document first. Ms. McHenry said it would be helpful if everyone has a clear sense of what people are working on.

Provider and Community Education: A More Formalized Educational and Credentialing Process
Dr. Monosky

Dr. Monosky noted that this topic has a significant degree of linkage to other topics that have been raised at this meeting. The committee considered three topics. The first was an analysis of emergency medicine to provide a new standard of education for EMS providers, beginning with systematic assessment of current practices, followed by development of a scope of practice and formalized credentialed education. The committee also considered alignment of current and future practices. A multidisciplinary task force should consider a national scope of practice with supporting data on national information systems. Revisions should be supported with funding, with a periodic revision process.

The third and most controversial topic was a strategy to establish a more formalized and institutionalized education process that would support IT systems and recognition of EMS providers by other health professions. A strategy is needed to develop the process.

Discussion

Getting paramedics into bachelor's programs or requiring that emergency medical technicians have bachelor's degrees are goals that go hand in hand. There is a progressive movement toward a degree requirement to become a practitioner like in other health professions. However, a degree requirement raises a number of issues. Getting a degree does not necessarily mean greater reimbursement, and a degree requirement might not send the right signal to many. A movement for this a few years ago created a huge chasm. This also has occurred in nursing.

Dr. Fallat said getting a degree should be voluntary and education should emphasize patient outcomes. Mr. Garrett cautioned that making changes in educational requirements can be frightening for some. Mr. Baird said his state (Oregon) went through grueling legislative battles after adopting an associate's degree requirement. Mr. Kaye said it would not be fair to walk away from all the work that has been invested in developing paramedic training programs.

Mr. Robbins said CMS and insurers should increase reimbursement based on education. Many individuals with degrees eventually earn more money. A degree requirement would elevate the profession, but he was not in favor of mandating a degree. Dr. Diaz commented that raising educational standards is an iterative process that will take years.

Public Comment

Paul Brown is executive consultant with DataTech911, which has a phase 1 Small Business Innovation Research contract with DHS to demonstrate the feasibility of using social media to improve situational awareness and support decision-making, preemptive response, and predicted outcomes for operational response by first responders. Social media and CAD feeds will be identified to assess their correlation. Phase 2 will establish a pilot program. Another DataTech911 project is EMS Data Analytics in Real Time (EMS DART), which focuses on using key performance indicators to get information to EMS personnel in real time so they can make a positive response.

Mike Hall, president of the American Ambulance Association, thanked the group and agreed that the field of EMS must move forward. To do that, there must be a way to calculate costs. His group has a survey method to do this.

Closing Remarks and Adjournment

Dr. Cunningham shared her experience from earlier this summer in Cleveland, where the Republican National Committee held its convention. In general, things went better than many expected. There was considerable security around the central zone. Groups of protestors who showed up at the last minute were welcomed by volunteers and located in designated camping areas with food and water within walking distance of the hotel zones. It worked out well. Police officers did not show up in riot gear. Most had bicycles and used them as non-confrontational

barriers. There were two fist fights and one man who burned himself setting an American flag on fire. He was arrested for burning some people around him. Law enforcement escorts were provided to get people into the convention zone. Descriptions of the efforts were shared the following week, so that some of the initiatives could be adopted as best practices.

Adjournment was moved and seconded, and Mr. Sinclair adjourned the session for lunch at 12:34 p.m. EDT. After lunch, the committees met until 5 p.m. EDT. Committee meetings were on site and open to the public.

Day 2: Thursday, September 8, 2016

Reconvene

Mr. Sinclair opened the meeting at 8:30 a.m. EDT.

Approval of April 18–19, 2016 Meeting Minutes

It was moved and seconded to approve the April minutes. The motion passed unanimously.

NEMSAC Committee Reports/Updates/Discussion/Action

Innovative Practices of EMS Workforce: Recognizing the EMS Workforce as Essential Decision-Makers Within the Health Care Industry and Assuring Adequate Fiscal Support
Mr. Robbins

A new document that replaced the earlier statement indicated recognition that the field of paramedicine has evolved and should be recognized as a profession. The mission and activities have expanded and taken on roles that were not described in the 1966 Highway Safety Act.

The committee provided an expanded list of terms for what this field of health care does and what practitioners are called.

The committee recommended that "paramedicine" become the standard generic term for the discipline that encompasses EMS, medical transportation, community paramedicine, and mobile integrated health care (MIH). Also, "medic" should be recognized as the inclusive standard term for practitioners, regardless of certification or licensure. FICEMS and DOT should work with states, certifying organizations, and professional groups to encourage widespread and legal use of the term "medic**"** as a general descriptor of practitioners in the profession of paramedicine.

Discussion

Mr. Sinclair said the nomenclature and recommendations are for the council to consider and will have to go through a public phase before they are adopted. He asked for any immediate feedback. Dr. Cunningham said the definition should state that paramedic service is a sector of the practice of medicine. Dr. Shah cautioned that the nomenclature has the potential to cause confusion if "paramedic" is used as an overarching term. He proposed "prehospital provider," a

term that would not be confused with the current nomenclature. Dr. Robbins said people are striving for a simple term with fewer syllables, something quick and short. Dr. Diaz commented that term paramedic is used everywhere but the United States and rolls off the tongue. Ms. Montera said clarity is needed, and it will take strategy and marketing.

Dr. Monosky said this is a good example of the council being bold, as Mr. Sinclair has directed. NEMSAC must take responsibility for it profession. Uniform nomenclature brings solidarity to the profession, reduces confusion, and bolsters his belief about education. Mr. Sinclair said this topic will require further reflection and dialogue.

Patient Care, Quality Improvement, and General Safety: Updating the Trauma System Agenda
Dr. Fallat

Dr. Fallat said the committee reviewed changes made to the recommendations about the trauma system agenda and revisions to the MTSPE. The final advisory is open to MTSPE revisions but does not mandate them. She will take the discussion back to the American College of Surgeons Committee on Trauma (ASCOT). She summarized wording changes that were made in concepts currently numbered 13, 14, 16, 21, and 22. They involve development of an integrated federal strategy to address recommendations, adding a continuum of care model, linking NEMSIS with the National Trauma Data Bank, a partnership between FICEMS and ASCOT to assess field triage criteria, and evaluating whether trauma systems should follow federal or state guidelines.

Discussion

Dr. Fallat noted that numbering the concepts beginning with No. 13 was a formatting error that she will correct. No. 13 should be No. 1. Ms. McHenry said an overall technical suggestion is to keep the recommendations as concise and straightforward as possible.

It was moved and seconded to accept the revised interim advisory on updating the trauma system agenda for the future and MTSPE document, incorporating the changes that have been discussed. The motion carried unanimously.

Provider and Community Education: (1) A More Formalized Educational and Credentialing Process; (2) Practice Analysis of Community Integrated Healthcare
Dr. Monosky

The main change was to flip the pieces of the advisory and turn No. 1 into No. 2 and No. 2 into No. 1. There were no changes in content and slight wording changes in No. 2 that emphasize that the transition to a required degree is not mandated and allows for options.

Dr. Monosky requested interim adoption of the recommendations, and it was so moved and seconded. The motion was approved unanimously.

The second advisory, which is about practice analysis, is the joint work of the education and data/IT committees and reflects the need for standardizing data collection information. It urges a

national MIH data collection summit to create a national standardized data dictionary.

Discussion

In wide-ranging discussion, council members praised bringing two committees together, which gives the recommendations more weight. Among the points made were that the scope of MIH practice varies from by state, that the community paramedic practice analysis is scheduled to be completed by September 2018, and that NEMSAC's vision is eventual full compatibility between NEMSIS and state and national data collections, including HL7 compatibility. Ms. Montera proposed exploration of requirements for core datasets. Dr. Braithwaite said the Patient Care, Quality Improvement, and General Safety committee discussed some of these topics, including making decisions about which of the hundreds of data points are worth continuing.

Further discussion considered whether the advisory was ready to move forward. Dr. Monosky said the intent of the advisory was to gather information and begin to assess commonalities. Dr. Diaz said this is the beginning of an analysis, and he thought it would be a living workgroup. It will take years to get to an endpoint, and the sooner the discussion begins, the sooner it will advance. Mr. Baird said he would omit the point that speculates about results. He thought the recommendation should simply be to conduct an analysis. Mr. Smith said the question is whether the intent of the summit would lead to state requirements. Mr. Sinclair said the practice analysis must precede the summit. Mr. Kaye said the recommendation is to assess the minimum dataset, see what fits with the current program, and continue to analyze that with a separate slot for additional data, gathering data about things the current data dictionary does not define.

Mr. Hooten said every major health care group is developing mobile health care datasets. His organization's program has been up since 2009. Can this data be aggregated locally before everyone starts collecting data? There is considerable ongoing work about data collection, data dictionaries, metrics, and related topics. NEMSAC is a bit behind the curve in this discussion. Several software vendors are working on this. Also, NEMSAC should connect to a national group putting together metrics for paramedicine using health care standards.

Mr. Sinclair suggested briefly tabling this advisory and coming back to it later in the meeting. There was general agreement among council members for this approach.

Naloxone National Practice Model
Ms. Montera

The fourth recommendation about reviewing new processes (page 2 of new document) added an introductory phrase, "As part of the ongoing re-evaluation and update process thus creating this as a living document ..." Dr. Braithwaite said the document needs some editing for grammar.

It was moved and seconded to accept the proposed advisory as a final recommendation. Ms. Montera thanked council members for their input. The motion passed unanimously.

Ad Hoc Committee on REPLICA
Dr. Shah

Dr. Shah detailed several minor wording changes that were made. It was moved and seconded that the revised advisory as written receive final approval. The motion for final approval of the REPLICA advisory passed unanimously.

Funding and Reimbursement Committee: EMS System Performance-based Funding and Reimbursement Model
Mr. Baird

This revised recommendation also did not have substantive changes, just wording modifications. Mr. Baird will work with Ms. Montera to ensure that the document uses the most appropriate terminology. A reference to the Social Security Act will be replaced with "regulatory change." Mr. Baird will clean up references to appendices.

It was so moved and seconded that the document be approved as an interim advisory with the suggested changes, and the motion was unanimously accepted.

Data Integration and Technology: Standardized Training for Local Data Managers to Ensure High-Quality Data

There were no changes to the document. It was moved and seconded to approve interim status, and the motion carried unanimously.

Universal Health Information, Real Time and Retrospective Patient Care Enhancement, and Integration with other Health Information

Dr. Diaz said there were no changes to the advisory, and it was moved and seconded to approve interim status. The motion was unanimously approved.

EMS Workforce as Essential Decision-Makers Within Health Care Community

Dr. Monosky said there were no comments or requests for changes in this document and moved that it be adopted with interim approval. The motion was seconded and unanimously approved.

Overall Alignment between EMS Scope of Practice Model and EMS Education Agenda

There were no changes, revisions, additions, or comments from the subcommittee meeting to consider the need for alignment of the 2000 EMS education agenda for the future, a systems approach, and the 2007 National EMS Scope of Practice model with the current practice of EMS medicine. It was moved and seconded to move forward on this topic as an interim advisory. The motion was approved unanimously.

Continuation of Discussion on Practice Analysis for Community Paramedicine MIH

The group convened during a break and wordsmithed the questioned portions of the advisory, which considers a new scope of practice education standard and standardized data dictionary.

The concerns with the recommendations were portions of last two major bullet points, which were revised. It was moved and seconded to accept the revised interim recommendation, and the motion was approved unanimously.

Election of Chair and Vice Chair

Ms. McHenry clarified the term of office for the chair and vice chair to be elected. The term will begin at end of this meeting and run through May 2017, which is when new NEMSAC appointments will be made. The new council will serve through May 2019. Currently, 19 council members are eligible for re-appointment in 2017, but there is no guarantee of re-appointment.

The council nominated three members for chair: Ms. Montera, Mr. Robbins, and Dr. Diaz. The final tabulation was 8 votes for Mr. Robbins, 7 for Ms. Montera, and 4 for Dr. Diaz. Mr. Robbins will take over as new NEMSAC chair.

The council nominated four members for vice chair: Dr. Monosky, Dr. Diaz, Dr. Braithwaite, and Ms. Montera. The final tabulation was 7 votes for Dr. Braithwaite, 5 for Dr. Diaz, 4 for Ms. Montera, and 3 for Dr. Monosky. Dr. Braithwaite will take over as the new NEMSAC vice chair.

NEMSAC Annual Report

The NEMSAC annual report has been circulated among council members and edited extensively, with some revisions. Many of the advisories that are included are interim. Mr. Sinclair asked council members how they want to move forward with the annual report. The revised version has not yet been circulated.

Ms. Montera added that she accepted 100 percent of the suggested feedback. All edits, comments, and additions have been incorporated in the updated document. The only things it does not yet included are the revised versions of the advisories considered at this meeting.

Ms. McHenry said Ms. Montera should incorporate changes from this meeting into the annual report and send it to the council for final approval. Only two of the advisories—REPLICA and naloxone —are final reports. The others are interim.

Mr. Sinclair said the annual report will be wordsmithed. He recommended that it be signed by the new chair and vice chair, but after further discussion, the council agreed that Mr. Sinclair and Ms. Montera would sign it, since it represents the work of the current council.

Public Comment

David Finger, of the National Volunteer Fire Council, thanked NEMSAC for posting the proposed advisories online a week in advance of the meeting. It was helpful for members of his group to consider how they wanted to respond. His group was uncomfortable with an education advisory that would require a bachelor's degree and more comfortable with the revisions.

Robert McClintock, EMS specialist with the International Association of Firefighters, also

expressed concerns about the education recommendation and emphasized the importance of retaining certification programs. Dr. Monosky reiterated that this is intended to be a strategic plan for transition with incremental changes and a period of time that allows for progression.

Dia Gainor, M.P.A., of the National Association of State EMS Officials, expressed concern that the changing nomenclature and formalizing education advisories fell short of addressing the regulatory rule of states and allowances and prohibitions related to terminology use. She asked the council to think about how those factors might be incorporated into the recommendations. Mr. Sinclair requested a list of specific recommendations; Ms. Gainor said she would do that.

Michael Touchstone, president of the National EMS Management Association, commended the council on taking a nomenclature measure forward and moving EMS to a profession. It is important to understand that language matters. This is not a new conversation, but finally it is being approached with force and authority.

NEMSAC Next Steps

Mr. Sinclair said the council, as currently composed, has two more meetings, in December 2016 and April 2017. Then there will be a re-appointment process for the 19 freshman members. He suggested that they begin to prepare their letters for submission. Ms. McHenry added that notification will be sent when the Federal Register posting is written, and she will inform members and let them know the steps to follow. Reappointments must submit a letter stating their desire to serve and information about whether they have changed jobs.

Ms. McHenry said the federal liaisons and current officers will work together with the new officers, and it might be helpful to plan a conference call with the four current and new officers. She will schedule regular conference calls with the new chair and vice chair to make sure activities are coordinated.

Dr. Fallat said the council had a discussion about 2-year term limits, and some questioned why terms could not be for 3 years, with reappointment for an additional 3 years. After 2 years, it feels like they are just getting started. Ms. McHenry said the 2-year term was congressionally mandated. It would be very difficult to change at this point.

Dr. Krohmer commented that his transition date from DHS to DOT was the day before this meeting, and he could not think of a better way to begin his new job. Regardless of the specific roles of individuals in the EMS system, over the years everyone's own worlds have expanded to include each other's disciplines. He said he looked forward to continuing the incorporation of disciplines and stakeholders, including mobile integrated health care. This discussion been valuable to him, and the comments of council members have reinforced what a talented group this is and the talent in the EMS community.

Ms. Altenhofen said the theme of the council seems to be to move this profession forward. The prior theme was more about safety.

Mr. Sinclair thanked Ms. Montera for her service and described her as the whip, the person who makes sure things are on task. He said it has been a great honor to chair this group. He began the

meeting by asking the council to be bold and courageous. There are two more meetings of this group, and the work continues. This is a time of significant change in the EMS profession. Change is coming from existential forces such as the press of aging baby boomers, millennials with their challenges, and a host of international challenges that will affect this country. The country continues to live under the threat of violence. All of this takes a toll. People are just beginning to understand behavioral issues, and the EMS field must be open to what it can do. He thanked the council for its work.

Adjournment

It was moved and seconded to adjourn the meeting. Mr. Sinclair adjourned the meeting at 11:12 a.m. EDT.

Appendix A: Council Members Present at Meeting

NEMSAC members and the sectors they represent:

Katrina Altenhofen, M.P.H.
Volunteer EMS
Washington, IA

Shawn Baird, M.A.
Private EMS
Portland, OR

Sabina Braithwaite, M.D., M.P.H.
Emergency Physicians
Wichita, KS

Carol Cunningham, M.D.
EMS Medical Directors
Akron, OH

Steven Diaz, M.D.
Hospital Administration
Augusta, ME

Eric Emery, B.A.
Tribal EMS
Rosebud, S.D.

Mary Fallat, M.D.
Trauma Surgeons
Louisville, KY

Val Gale, B.A.
At-large member
Gilbert, AZ

Brett Garrett
EMS Practitioners
McCalla, AL

Douglas Hooten, M.B.A.
Local EMS Service Administrators
Fort Worth, TX

Sean Kaye, B.A.
EMS Data Managers
Chapel Hill, NC

David Lucas
911 Dispatcher
Lexington, KY

Chad McIntyre
Air Medical
Jacksonville, FL

Keith Monosky, Ph.D., M.P.M.
EMS Educators
Ellenburg, WA

Anne Montera, B.S.N., NEMSAC vice chair
Public Health Sector
Eagle, CO

Vincent Robbins, M.S.
Hospital-Based EMS
Hamilton Square, NJ

Freddie Rodriguez
State and Local Legislative Bodies
Pomona, CA

Manish Shah, M.D.
Pediatric Emergency Physicians
Houston, TX

John Sinclair, NEMSAC chair
Fire-based EMS
Ellenburg, WA

Lynn White, M.S.
EMS Researchers
Copley, OH